Intravenous Therapy Practicum
Skill Sheet

Training Agency / Program _____

Student Name _____ **EMT #** _____

Social Security # _____ **Hospital / Agency** _____

Attempt	Date	Successful	Unsuccessful	Person Supervising this IV (signature & title)
1				
2				
3				
4				
5				
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17				
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20				

I certify that the above-named student performed the skill of intravenous therapy as required by the EMS agency/licensed Instructor-Coordinator as outlined in the special course guidelines/requirements.

_____ _____

Date **Hospital / Agency Representative**

_____ _____

Date **Instructor-Coordinator / Program Director**